3 December 2020

New Test of Competence: Nursing Associates CBT and OSCE

Jack Bland
Senior International Registration Manager

Housekeeping

- Everyone, except the presenters, are automatically muted
- The “raise your hand” feature will not be used today
- Use the “?” feature or speech bubble to submit any questions or comments at any time
- Audio-only participants can email questions and comments to ToC@nmc-uk.org
- We may not be able to address individual points but everything is being noted for consideration
- You can download the slides using the resource function
- The session will be recorded

Today's agenda

2:30 pm	**Welcome, scene setting and latest NMC updates** Jack Bland, Senior International Registration Manager, NMC
2:35 pm	**Design overview** Sarah Maughan, Director, AlphaPlus
2:45 pm	**Examples of CBT content** Sarah Maughan, Director, AlphaPlus
2:50 pm	**Examples of AIE content** Sarah Maughan, Director, AlphaPlus
2:55 pm	**Examples of skills content** Sarah Maughan, Director, AlphaPlus
3:00 pm	**Support Materials** Sarah Maughan, Director, AlphaPlus
3:05 pm	**Q&A session** Jack Bland, Senior International Registration Manager, NMC Sarah Maughan, Director, AlphaPlus Kate Wills ,Vice Principal Group Curriculum and Quality, The Cornwall College Group Lead IQA Healthcare Standards, Pearson
3:25 pm	**Next steps and closing** Jack Bland, Senior International Registration Manager, NMC

Previous webinars

- Over 700 people joined our first five webinars and over 1,000 people have already watched the recordings:
  - Overview of the new Test of Competence
  - The new Computer Based Test (CBT)
  - Introduction to the new Nursing OSCE APIE stations
  - Introduction to the new Nursing OSCE Skills stations
  - New Test of Competence: Midwifery CBT and OSCE
- Thank you to everyone who attended, asked questions and submitted feedback
- If you weren't able to join these webinars, you can watch the recordings and download the presentation slides on our website **www.nmc.org.uk/registration/toc-review**

Nursing Associates on our register

- We first started welcoming nursing associates to join the register in January 2019
- Since then, 3,078 nursing associates have joined our register via the UK, overseas and EU registration routes
- UK trained nursing associates predominantly make up this figure, however, we've received over 220 applications from overseas candidates since this part of the register was created
- The Objective Structured Clinical Exam (OSCE) for this pathway is currently delivered by The University of Northampton

NMC Test of Competence: Nursing Associates

Alpha*Plus* Consultancy Ltd.

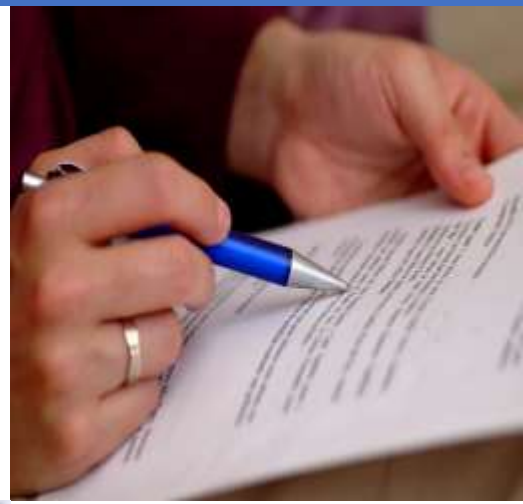
December 2020

Partnership

We work in partnership with our clients. This is more than a cliché for us: we care about the services we provide and the impact they have on learners. Experience has shown us that the best impact our work can have is when it is undertaken alongside our clients so we make partnership a key feature of our project approach and management method.

Quality

We manage projects effectively and to the highest quality, freeing up experts to concentrate on their specialism, but ensuring that activities are manage to meet expectations. This means only making promises that we know we can keep, and remembering the promises we have made to make sure we deliver.



Expertise

We ensure our teams consist of genuine sector experts with understanding in breadth and depth of both the theory and the practical complex everyday challenges faced by education providers.

Development

We are committed to the improvement of our staff, both to promote the long-term development of our business and as an end in itself: we believe in the value of education for all.

Educationalists

We are educationalists with a strong commitment to improving teaching, learning and assessment, based on intellectual integrity, sound evidence and innovative approaches.

Overview of design

Format of the new test of competence: Nursing Associates

Component	Design	Marks	Timing
CBT (Computer Based Test)	Part A: Numeracy	15	30 minutes
	Part B: Theory	100	2 hours and 30 minutes
OSCE (Objective Structured Clinical Exam)	10 stations: - 3 station 'provision and monitoring of care' consisting of: • Assessment • Implementation • Evaluation - 5 skills stations consisting of: standalone or paired skills - 1 professional behaviours station - 1 critical appraisal station	Variable by station according to task-specific criteria	Up to 2 hours and 30 minutes Provision and monitoring of care stations: • Assessment station: 20 • Implementation station: 16 • Evaluation station: 10 Skills stations, critical appraisal and professional behaviours stations: • Up to 8 minutes each or 16 minutes for each pairing

OSCE overview: nursing associates

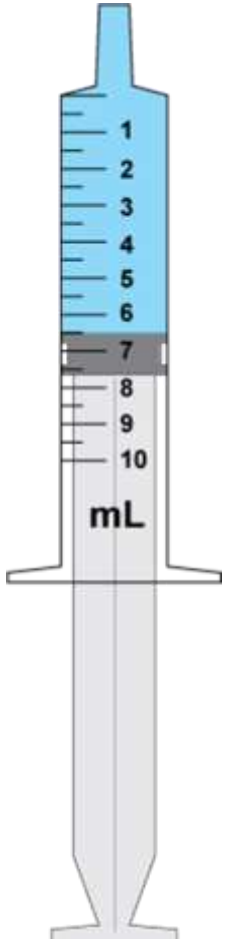
Scenario	A	I	E	Linked Skill 1	Linked Skill 2	Skill 3	Skill 4	Skill 5	EBP	Professional Values
Hospital Admission										
Post operative return to the ward										
Community - Gaining Informed Consent										
Patient with Pneumonia (Re-purpose)										

Nursing Associate Skill Stations for the ToC

Skill
Administration of Inhaled Medication (AIM)
Blood glucose monitoring
Pain Assessment
Oxygen therapy
Fluid Balance
Hospital Admission and Documentation
CSU
Physiological Observations, recording and response
Pain Assessment
Peak Expiratory Flow Rate (PEFR)
Pressure area assessment
Gaining informed consent
Subcutaneous Injection S/C

Examples of CBT content

Example Part A: numeracy question – Measuring the correct dose



What is the volume that has been drawn up into the syringe?

Answer = ___**6.5 mL**_____

Example Part A: numeracy question – metric units

A patient has been prescribed 0.4 g of ibuprofen.

What is the dose in mg?

Answer = _____**400** _____ **mg**

Example Part A: numeracy question – oral medications

A patient has been prescribed 1 g of carbocisteine solution.

What volume should be administered?

__**25 mL**_____

Example Part A: numeracy question – fluid balance chart

Complete the following fluid balance chart to calculate if the patient has gained or lost fluid over a 24-hour period.

If the patient has gained fluid you should include '+' before your balance answer, e.g. +100 mL. If the patient has lost fluid you should include '-' before your balance answer, e.g. -100 mL.

Patient's name: Jack Jones Hospital number: 3861050 Chart number: 1
IV Fluid type and rate: 500 mL 0.9% sodium chloride 125 mLs/hour
Date: 26/03/20 Ward: G7

Time	Input			Output			
	Oral (mL)	Intravenous infusion (mL/hour)	Total (mL)	Urine (mL)	Aspirate/ vomit (mL)	Other _____ (mL)_	Total (mL)
0100							
0200							
0300							
0400							
0500							
0600		125					
0700		125					
0800	100	125		140			
0900		125					
1000							
1100							

Example Part B: clinical question – generic (1)

Urgency and frequency of micturition is a symptom of . . .

Choose the correct option to complete the sentence.

A Dehydration

B Infection

C Retention

D Obstruction

- Primary Platform Statement = 3.9
- Bloom's level = Remember and understand

Example Part B: clinical question – generic (2)

A nursing associate delegates a task to non-registered member of the heath care team. Who is accountable for the care delivered?

Choose the correct answer.

A The nursing associate

B The non-registered health care worker

C The registered nurse

D The medical doctor

- Primary Platform Statement = 4.5
- Bloom's level = Remember and understand

Example Part B: clinical question – generic (3)

A nursing associate is visiting a patient at home following a stroke. The patient is finding it difficult to swallow soft foods. To whom will the district nurse refer the client?

Choose the correct answer.

A The occupational therapist for feeding aids
B The patient's GP for further investigations
C The speech and language therapist for assessment
D The social worker for additional care to be provided

- Primary Platform Statement = 3.7
- Bloom's level = Apply and analyse

Example Part B: clinical question – generic (4)

A nursing home resident is declining food. On further examination, multiple mouth ulcers and ill-fitting dentures are discovered. What course of action does the nursing associate take?

Choose the correct answer.

A Refer the patient to a dentist, GP and dietitian

B Remove the ill-fitting dentures, offer a soft diet and mouth wash

C Advise wearing dentures for eating only, and apply a mouth ulcer treatment

D Take the dentures to a nearby repair lab to have them made smaller

- Primary Platform Statement = Annex B
- Bloom's level = Evaluate and create

Examples of AIE content (draft)

Assessment: Candidate briefing

Please conduct a holistic assessment assessing the patients physical, psychosocial, spiritual and sexual care needs.

As part of your assessment please complete an **A – E assessment** (Airway, Breathing, Circulation, Disability, Exposure), and take and **record the patient vital signs** (blood pressure, temperature, pulse rate, oxygen saturations, respiratory rate) and **calculate a National Early Warning Score 2** (NEWS2) score. You will also need to complete a **Malnutrition Universal Screening Tool** (MUST) assessment and calculate the score, and record **blood glucose levels** and obtain a **CSU**.

Depending on the patient's circumstances and condition you may wish to focus on some areas of assessment in more depth than others.
An observation chart and MUST tool have been provided and must be completed within the station.

You have **20 minutes** to complete this station, **including the completion of the following documentation: NEWS2 score** and **MUST assessment.**

Id	Assessment Criteria
1	Assesses the safety of the scene and privacy and dignity of the patient.
2	Cleans hands with alcohol hand rub, or wash with soap and water and dry with paper towels following WHO guidelines.
3	Introduces self to person.
4	Checks ID with person (person's name is essential and either their date of birth or hospital number) verbally, against wristband (where appropriate) and documentation.
5	Checks for allergies verbally and on wrist band (where appropriate).
6	Gains consent and explains reason for the assessment.
7	Uses a calm voice, speech is clear, body language is open, personal space appropriate.
8	Conducts an A-E assessment **(please refer to examiner guidance for specific scenarios); v**erbalisation allowed:
8a	**Airway:** Clear; no visual obstructions
8b	**Breathing:** Respiratory rate; rhythm; depth; oxygen satuation level; respiratory noises (rattle wheeze, stridor, coughing); unequal air entry; visual signs of respiratory distress (use of accessory respiratory muscles, sweating, cyanosis, 'see-saw' breathing)
8c	**Circulation:** Heart rate; rhythm; strength; blood pressure; capillary refill; pallor and perfusion
8d	**Disability**: conscious level using ACVPU; presence of pain; urine output; blood glucose;
8e	**Exposure**: Takes and records temperature; asks for the presence of bleeds, rashes, injuries; obtains a medical history
9	Accurately measures and documents the patient's vital signs and specific assessment tools.
10	Calculates NEWS2 score accurately. For subdural scenario only: accurately calculate Glasgow Coma Scale.
11	Accurately completes document: sign, date and time on assessment charts.
12	Conducts a holistic assessment relevant to the patient's scenario.
13	Disposes of equipment appropriately - verbalisation accepted.
14	Cleans hands with alcohol hand rub, or wash with soap and water and dry with paper towels following WHO guidelines - verbalisation accepted.
15	Acts professionally throughout procedure in accordance with the NMC (2018) The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates.

Scenario
You are a nursing associate working on a Medical Ward at St Jakes Hospital. Following a medical assessment, you have been asked to undertake the medication administration for Patrick Rushworth. Please administer and complete the documentation of their medications in a safe and professional manner.

- Talk to the person.
- Please verbalise what you are doing and why to the examiner.
- Read out the chart and explain what you are checking/giving/not giving and why.
- Complete all the required drug administration checks.
- Complete the documentation and use the correct codes.
- The correct codes for non-administration are on the chart.
- Check and complete the last page of the chart.

Id	Assessment Criteria
1	Cleans hands with alcohol hand rub, or wash with soap and water and dry with paper towels following WHO guidelines.
2	Introduces self to person.
3	Seeks consent from person or carer prior to administering medication.
4	Checks allergies on chart and confirms with the person in their care, also note red ID wristband (where appropriate).
5	Before administering any prescribed drug, looks at the person's prescription chart and correctly checks **ALL** of the following: Correct: • Person (Check ID with person: verbally, against wristband (where appropriate) and documentation), • Drug • Dose • Date and time of administration • Route and method of administration • Diluent (as appropriate) • Any Allergies.
6	Correctly checks **ALL** of the following*:* • Validity of prescription • Signature of prescriber • Prescription is legible If any of these pieces of information are missing, are unclear or illegible then the nurse should not proceed with administration and should consult the prescriber.
7	Considers contraindication where relevant and medical information prior to administration (prompt permitted) (this may not be relevant in all scenarios).
8	Provides a correct explanation of what each drug being administered is for to the person in their care (prompt permitted).
9	Administers drugs due for administration correctly and safely.
10	Omits drugs not to be administered and provides verbal rationale (ask candidate reason for non-administration if not verbalised).
11	Accurately documents drug administration and non-administration.
12	Acts professionally throughout procedure in accordance with the NMC (2018) The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates.

Scenario
You are a nursing assistant working on a Medical Ward at St Jakes Hospital and have undertaken a nursing assessment of Patrick Rushworth. You now need to handover to a colleague on an older adult ward as the patient is being transferred. Most recent observations were: Temperature: 36.7^{0}C Pulse: 79 beats per minute Respirations: 22 beats per minute Oxygen Saturations: 92% on air Blood Pressure: 164/92 CSU Labstix showed Blood +++ Specimen sent to lab.

Using the Situation, Background, Assessment and Recommendation (SBAR) tool please make notes regarding your patient and use this to verbally hand information over to your colleague (examiner).

You have **5 minutes** to make notes on the SBAR form (this is not assessed) and up to **5 minutes** to complete the verbal handover to the examiner.

Id	Assessment Criteria
Situation	
1a	Introduces self and the clinical setting.
1b	States the patient's name, hospital number and/or DoB, and location.
1c	States the reason for the handover (where relevant).
Background	
2a	States date of admission / visit / reason for initial admission / referral to specialist team and diagnosis.
2b	Notes previous medical history and relevant medication/social history.
2c	Gives details of current events and details findings from assessment.
Assessment	
3a	States most recent observations, any results from assessments undertaken and what changes have occurred.
3b	Identifies main nursing needs.
3c	States nursing and medical interventions completed.
3d	States areas of concerns.
Recommendation	
4	States what is required of the person taking the handover and proposes a realistic plan of action.
Overall	
5	Verbal communication is clear and appropriate.
6	Systematic and structured approach taken to handover.
7	Acts professionally throughout procedure in accordance with the NMC (2018) The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates.

Example of skills stations

Skill Example: Stoma bag change

Scenario
You are working on a post-operative surgical ward. You are caring for Kendi Abara who has undergone a Right Hemicolectomy and colostomy formation. They are three days post-surgery, the one-piece stoma bag needs to be replaced and Kendi is currently not well enough to do this themselves. **Please change the patient's stoma bag according to current evidence based practice.** All identification checks have been completed and the patient has no known allergies. The trolley has already been cleaned prior to the procedure. You are not required to document anything during this skills station.

Resource List

1. Dougherty, L., Lister, S. E. and West-Oram, A. (2015)*The Royal Marsden Manual of Clinical Nursing Procedures (Student Edition).* 9th edition. Chichester: Wiley Blackwell
2. McGrath, A. (2017) Stoma-associated problems: the important role of the specialist nurse. British Journal of Nursing, vol. 26, 5, pp. 30-31
3. Free website: https://www.coloplast.co.uk/Stoma/people-with-a-stoma/after-stoma-surgery (Accessed 9th October)

Stoma bag change: marking criteria

Id	Assessment Criteria
1	Introduces self. Explains procedure to the person and gains consent
2	Ensures that the patient is in a comfortable and suitable position where they are able to watch the procedure
3	Checks all equipment required for the procedure including expiry dates: new colostomy bag, a disposable bag, gauze, scissors and a receptacle are needed
4	Cleans hands with alcohol rub or wash with soap and water and dry with paper towels according to the WHO guidelines.
5	Dons a disposable plastic apron and non-sterile gloves
6	Places a small protective disposable pad below the stoma area to protect patient's clothes from accidental spillage
7	Removes the stoma bag slowly using adhesive remover. Peels the adhesive off the skin whilst using the opposite hand to apply pressure on the surrounding skin.
8	Folds the removed stoma bag to prevent spillage before placing into a disposable bag
9	Removes any visible faeces or mucus from the stoma with a piece of gauze soaked in warm tap water
10	Examines the stoma site and peristomal skin for soreness, ulceration, signs of infection and other unusual signs site such as unusal colour (black or pale), foul odour or discharge
11	Washes the skin around the stoma (peristomal area) with gauze soaked in warm tap water
12	Gently dries the peristomal skin with dry gauze, ensuring the area is thoroughly dry
13	Measures the stoma site, cuts a hole in the adhesive flange of the new bag aiming for 3mm larger than the site.
14	Applies the clean appliance, using the flat of hand to gently press to ensure it adheres in all areas.
15	Disposes of equipment including apron and gloves appropriately - verbalisation accepted
16	Cleans hands with alcohol rub or wash with soap and water and dry with paper towels according to the WHO guidelines.
17	States would document the change of stoma bag in nursing notes and would report any abnormalities to the stoma nurse and/or surgical team
18	Acts professionally throughout procedure in accordance with the NMC (2018) The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates

Professional Values Example

Scenario
You are just about to commence the lunchtime drug round, you enter the clinical room and one of your nursing colleagues is in the room already. You witness the nurse take a 30 milligram Codeine Phosphate tablet from the drug cupboard. She puts it into her mouth and swallows it in front of you. You ask if she is ok and she tells you she needs the tablet for a headache. As far as you are aware this is an isolated incident.

- Using your knowledge of NMC (2018) The Code: “Professional standards of practice and behaviour for nurses, midwives and nursing associates”, consider the professional, ethical and legal implications of this situation.
- Please summarise the actions you would take in a number of bullet points.
- This is a silent written station. Please write clearly and legibly.

Professional Values Mark Scheme

Id	Assessment Criteria
1	Recognises that taking NHS/hospital property for personal use or gain including medication is prohibited
2	Recognises professional duty to report any concerns that may result in compromising the safety of patients in their care or the public and failure to report concerns may bring their own fitness to practise into question and places own registration at risk
3	Raises concern with manager at the earliest opportunity verbally or in writing. Recognises the need to be clear, honest and objective about the reasons for concern, reflecting duty of candour
4	Recognises that the manager may wish an incident report to be completed: recording the events, steps taken to deal with the matter including the date, who the concern was raised with
5	Takes into consideration own responsibility for the safety of the colleague: considers the effects of codeine on their ability to work and drive home
6	Considers that the colleague may need a medical review for their headache or may need support in dealing with a substance misuse problem
7	Acknowledges the need to keep to and uphold the standards and values set out in the code: prioritise people, practise effectively, preserve safety and promote professionalism and trust
8	Handwriting is clear and legible

Evidence based Practice Example

- Read the scenario and the summary of the research below.
- Please identify the main points from the summary and apply the findings to the scenario below.
- This is a silent written station. Please write clearly and legibly.

Scenario
You are working on a surgical ward. Your patient Mr. Long, a 75 year old gentleman has been admitted for an elective inguinal hernia repair tomorrow. The surgeon has explained the procedure and consented Mr. Long for his operation. The surgeon mentioned that Mr. Long would be kept warm during his operation. Mr. Long asks you why keeping him warm is necessary and what the best way of doing this is.

Article Summary

A systematic review in a well-regarded peer reviewed journal appraised the findings of the available independent studies comparing methods of peri-operative warming. The review found that:

•Unintentional peri-operative hypothermia occurs in up to 70% of patients undergoing surgery and is more common in patients older than 70 years who have a preoperative systolic blood pressure < 140 mmHg, low basic mass index, diabetes, or immune deficiency, and whose surgeries require a long operation time.

•Peri-operative hypothermic was associated with an increased risk of: infection, delayed wound healing, prolonged and greater bleeding, slow recovery from anesthetic, myocardial ischaemia and prolonged shivering and discomfort.

•'Forced-air warming' (a devise that blows warm air through a disposable blanket with holes) was more effective than passive insulation and circulating-water mattresses.

•Patients who received forced-air warming reported higher levels of thermal comfort following surgery.

The review concluded that peri-operative forced air warming significantly reduced surgical complications and improved patient comfort post operatively

Documentation

Candidate Name: _____

What is the relevance of the findings from this research for Mr. Long and what advice would you give him?

Give your responses here as bullet points:

……..

……..

Evidence based Practice Mark Scheme

Id	Assessment Criteria
1	Summarise the main findings from the article summary and draw conclusion, making recommendations for practice.
1a	Write clearly and legibly.
1b	Informs Mr. Long that without intervention it is common for patients to lower their temperature during an operation.
1c	Advises Mr. Long as he is over 70 years old he is at increased risk of peri-operative hypothermia.
1d	Advises Mr. Long that warming him during surgery helps reduce the risk of infection, prolonged and greater bleeding, and heart damage. Warming promotes his recovery from anesthetic and wound healing.
1e	Advises Mr. Long that the best method to warm him during his procedure is a devise that blows warm air through a blanket.
1f	Informs Mr. Long that received warming during surgery should improve his post-operative comfort levels.

Support Materials

Candidate Support

- The examples used in this presentation are taken from the candidate support materials
- These support materials will be available in advance from the learning platforms held by each of the Test Centres in the new year
- There is more information about the support materials in the Overview presentation which was recorded and can be found https://www.nmc.org.uk/registration/toc-review/

Q&A session

Next steps

Coming up

- Register on our website - https://www.nmc.org.uk/registration/toc-review/
- Sign up for monthly updates - https://r1.dotmailer-surveys.com/b2129ae8-114gax68

Thank you